

# DT CREDENTIAL REISSUE FORM

## Kentucky Board of Nursing

312 Whittington Pky Ste 300  
Louisville KY 40222-5172  
502-429-3300 or 800-305-2042

**\$35 FEE FOR EACH CARD REQUESTED**

**(Fee is non-refundable)**

**Please type or print using capital letters and black ink.**

### Section 1: Biographical Data

Last Name	<input type="text"/>	
First Name	<input type="text"/>	M.I. <input type="text"/>
Maiden Name	<input type="text"/>	
Street	<input type="text"/>	
City	<input type="text"/>	State <input type="text"/>
Zip	<input type="text"/> - <input type="text"/>	County of Residence <input type="text"/>
Home Phone	<input type="text"/> - <input type="text"/> - <input type="text"/>	Daytime Phone <input type="text"/> - <input type="text"/> - <input type="text"/>
Social Security #:	<input type="text"/> - <input type="text"/> - <input type="text"/>	Credential #: <input type="text"/>

### Section 2: Reason for Reissue

Please fill in the appropriate circle indicating the reason for this request. **Your credential card MUST BE RETURNED with this form if you are requesting a change of name, and you must submit a copy of a legal name change document with this application.**

Original Credential Was: ☐ Lost ☐ Stolen ☐ Never Received

### Section 3: Notary

I certify that I am the person who is referred to in the foregoing application for reissue of a Kentucky dialysis technician credential; that the statements contained herein are true in every respect; that I have read and understand this application. I further understand that the falsification of any information contained herein will be cause for disciplinary action.

**Applicant's Signature**

Subscribed and sworn to before me by \_\_\_\_\_  
(Applicant's Name)

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

**State Of**

**Commission Expires**

SEAL

**Notary Public's Signature**

For Office Use Only

Cred. Status: \_\_\_\_\_

N/C Received:: \_\_\_\_\_

2/2005